STATE OF CALIFORNIA
DWC DISTRICT OFFICE
E-COVER SHEET

AUG 2 1 2019

Companion Cases Exist ☐

More than 15 Companion Cases ☐

Location*: CTL

Walk Thru Yes ○ No ◉

Date: (MM/DD/YYYY) 08/19/2019

Case Number:* ADJ12031731

SSN(Numbers Only)

○ Specific Injury (If Specific Injury, use the start date as the specific date of injury)

○ Cumulative Injury (START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

Body Part 1 :

Body Part 2 :

Body Part 3 :

Body Part 4 :

Other Body Parts :

Please check unit to be filed on (check only one box)*

◉ ADJ ○ DEU ○ SIF ○ UEF ○ SAU ○ INT ○ RSU

Companion Cases

Case 1:

○ Specific Injury (If Specific Injury, use the start date as the specific date of injury)

○ Cumulative Injury (START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

Body Part 1 :

Body Part 2 :

Body Part 3 :

Body Part 4 :

Other Body Parts :

Case 2:

○ Specific Injury (If Specific Injury, use the start date as the specific date of injury)

○ Cumulative Injury (START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

Body Part 1 :

Body Part 2 :

Body Part 3 :

Body Part 4 :

Other Body Parts :

DISTRICT OFFICE - DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

Date (MM/DD/YYYY)*	08/19/2019	Date Of Original Lien* (MM/DD/YYYY)		☐ Amended Lien

Case Number	ADJ12031731

(Choose only one)

○ a specific injury on _____ (MM/DD/YYYY)

◉ a cumulative trauma injury which began on 06/25/2018 (START DATE: MM/DD/YYYY) and ended on 02/15/2019 (END DATE: MM/DD/YYYY)

SSN (Numbers only)	217257160
Date of Birth	09/27/1978 (MM/DD/YYYY)

Injured Worker

First Name	JONATHAN
MI	
Last Name	SHOCKLEY
Address/PO Box	1000 SUTTER ST # 123
City	SAN FRANCISCO
State	CA
Zip Code (Numbers Only)	94109

Lien Claimant

Organization*	EDD SDI OAKLAND
First Name	
MI	
Last Name	
Address/PO Box*	PO BOX 1857
City*	OAKLAND
State*	CA
Zip Code* (Numbers Only)	94604
Phone* (Numbers Only)	5102854437

Lien Claimant Attorney/Representative

○ Law Firm/Attorney ○ Non Attorney Representative ◉ Lien Claimant not represented

Lien Claimant Law Firm/Representative	
First Name	
Last Name	
Address/PO Box	
City	
State	
Zip Code (Numbers Only)	
Phone (Numbers Only)	

Employer

Name	CARDIONET LLC
Address/PO Box	1000 CEDAR HOLLOW ROAD
City	MALVERN
State	PA
Zip Code (Numbers Only)	19355

Insurance Carrier or Claims Administrator Information

Name	CHUBB GROUP LOS ANGELES
Street Address/PO Box	PO BOX 42065
City	PHOENIX
State	AZ
Zip Code (Numbers Only)	85080

Employer or Claims Administrator Attorney/Representative (if known)

Name	COLANTONI COLLINS SAN FRANCISCO
Address/PO Box	201 SPEAR ST STE 1100
City	SAN FRANCISCO
State	CA
Zip Code (Numbers Only)	94105

OPENING LIEN

1. The undersigned hereby notifies the Division of Workers' Compensation (DWC) that payments of unemployment compensation disability ☑ * State Disability Insurance (SDI) or family temporary disability insurance ☐ * Paid Family Leave (PFL) insurance benefits are being made at the weekly rate of* $447.00 (Weekly Rate), Commencing* 06/08/2019 (Commencement Date) and continuing. Total benefit payments will not exceed $9,681.00 (Not to Exceed Amt). Request is made that these payments be determined and allowed as a lien in the settlement of this case. Upon cessation of payments and on the request of the DWC, an amended "Notice and request for Allowance of Lien" will be filed to cover the totals paid.

ADDITIONAL LIEN

2. The undersigned hereby notifies the DWC that additional payments of unemployment compensation disability ☐ State Disability Insurance (SDI) or family temporary disability insurance ☐ Paid Family Leave (PFL) insurance benefits are being made at the weekly rate of _____ (Weekly Rate), Commencing _____ (Commencement Date) and continuing. Total benefit payments will not exceed _____ (Not to Exceed Amt) Request is made that these payments be determined and allowed as a lien in the settlement of this case. Upon cessation of payments and on the request of the DWC, an amended "Notice and request for Allowance of Lien" will be filed to cover the total paid.

AMENDED LIEN

3. The undersigned hereby requests the DWC to determine and allow as a lien the sum stated below as "Total," which represents the amount of unemployment compensation disability and/or family temporary insurance benefits paid to date, plus applicable interest pursuant to California Unemployment Insurance Code section 2629.1(e) , and California Labor Code section 4904. Further benefits will be paid if the employee is found eligible and the DWC notified of any resumption of payments. Upon cessation of these continued payments or on the request of the DWC, a further amended lien will be filed.

Filed under Labor Code section 4903(f):

SDI benefits were paid at the weekly rate of _____ for the periods shown below:

Filed under Labor Code section 4903(h):

PFL benefits were paid at the weekly rate of [ ] for the periods shown below:

1. [ ] days at $ [ ] per day. From [ ] to [ ]
   Inclusive ☐ SDI ☐ PFL

2. [ ] days at $ [ ] per day. From [ ] to [ ]
   Inclusive ☐ SDI ☐ PFL

3. [ ] days at $ [ ] per day. From [ ] to [ ]
   Inclusive ☐ SDI ☐ PFL

4. [ ] days at $ [ ] per day. From [ ] to [ ]
   Inclusive ☐ SDI ☐ PFL

5. [ ] days at $ [ ] per day. From [ ] to [ ]
   (MM/DD/YYYY) (MM/DD/YYYY)
   Inclusive ☐ SDI ☐ PFL

Total* : [ ]

PROOF OF SERVICE

I declare I have delivered or mailed a copy of this document on 08/19/2019 (MM/DD/YYYY) to each of the persons named above and listed below. Field size limited to 1323 characters

JONATHAN SHOCKLEY
1000 SUTTER ST # 123
SAN FRANCISCO, CA 94109-5818
UNITED STATES
CARDIONET LLC
EMPLOYER
1000 CEDAR HOLLOW ROAD
MALVERN PA 19355
CHUBB GROUP LOS ANGELES
CLAIMS ADMINISTRATOR
PO BOX 42065
PHOENIX AZ 85080
COLANTONI COLLINS SAN FRANCISCO
LAW FIRM
201 SPEAR ST STE 1100
SAN FRANCISCO CA 94105
FARBER OAKLAND
LAW FIRM
333 HEGENBERGER RD STE 504
OAKLAND CA 94621

If other persons should be served with this document, please notify the Employment Development Department at the above address.

State of California
Employment Development Department

S JOSEF DE LA VEGA

(Lien Claimant)

Employment Development Department
State of California

Notice of Service / Request for Medical Records

Date ..... August 19, 2019

Claim ID..... DI-1005-856-302
Applicant..... Jonathan Shockley
WCAB Case No.. .....ADJ12031731
Employer..... Cardionet LLC
Date of Injury.....2/15/19
Insurance Claim No. 040519008736
Insurance Carrier: Chubb Group Los Angeles

☒ Enclosed are copies of medical reports to support the EDD lien pursuant to Labor Code, Section 4903.1(c).

☐ Demand is hereby made on the defendant(s) for all medical and rehabilitation reports in their possession for the above-referenced Workers' Compensation Appeals Board (WCAB) case.

☐ Medical reports have NOT been served to any parties. This information is protected by Code of Federal Regulations, Title 42, Part 2 and California State law, which prohibit making further disclosure of it without the specific written consent of the applicant. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Medical reports will be served on the WCAB upon demand or receipt of notice of a Mandatory Settlement Conference or Trial.

☐ Medical reports have been served on the WCAB but not other parties of record. This information is protected by Code of Federal Regulations, Title 42, Part 2 and California State law, which prohibit making further disclosure of it without the specific written consent of the applicant. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I declare I have served a copy of this document and any enclosures on 8/19/19 to the persons listed above and below. Parties served by personal delivery are identified by an asterisk(*).

Josef De La Vega/MH
Disability Insurance Program Representative

Farber Oakland | Colantoni Collins San Francisco | Chubb Group Los Angeles

If other persons should be served with this document, please notify the Employment Development Department at the address indicated on the Notice and Request for Allowance of Lien.

EDD Employment Development Department
State of California

You are responsible for providing your claim receipt number to your physician/practitioner so they may complete and submit a medical certification for your claim. Your claim form is not complete without the Physician/Practitioner's Certificate. For faster processing, your physician/practitioner may complete and submit this form online at www.edd.ca.gov.

Alternatively, your physician/practitioner may submit the Physician/Practitioner's Certificate using the paper "Claim for Disability Insurance (DI) Benefits", DE 2501 form and mailing it to the EDD. Have your physician/practitioner complete and sign "Part B – PHYSICIAN/PRACTITIONER'S CERTIFICATE." Certification may be made by a licensed physician or practitioner authorized to certify to a patient's disability or serious health condition pursuant to California Unemployment Insurance Code, Section 2708. If you are under the care of an accredited religious practitioner, obtain a "Claim for Disability Insurance Benefits - Religious Practitioner's Certificate," DE 2502, by calling 1-800-480-3287 and ask your religious practitioner to complete and sign it. Rubber stamp signatures are not accepted.

Your completed claim form must be received no earlier than 9 days, but no later than 49 days, after the first day you became disabled. If your completed claim form is late, you may lose benefits. Most claims are processed within 14 days of receipt of a properly completed claim form, which includes your portion of the DE 2501 and the Physician/Practitioner's Certificate.

If you are receiving temporary workers' compensation benefits and are filing for reduced Disability Insurance benefits for the same days, "PART B – PHYSICIAN/PRACTITIONER'S CERTIFICATE" of this form is not required, however after filing, contact SDI by calling 1-800-480-3287.

Submitted By:	JONATHAN D SHOCKLEY	Submitted On:	06-25-2019 12:00 AM
Entered By:	220-50002	Entered Date:	06-25-2019 12:00 AM

Claim for Disability Insurance (DI) Benefits - Physician/Practitioner's Certificate (DE 2501)

Form Receipt Number: R100000080765070

Section 1 - Patient Information

Patient's Name:	JONANTHAN D SHOCKLEY
Receipt Number:	
Social Security Number:	217-25-7160
Date of Birth:	09-27-1978
File Number:	

Section 2 - Physician/Practitioner Information

Name:	PATRICK O LANG
License Number:	A106890
State of Licensure:	CA
Treatment Address:	601 VAN NESS AVE SUITE 2018 SAN FRANCISCO, CA 94102 United States
Phone Number:	415-751-4263
License Type:	

EDD Employment Development Department
State of California

Specialty (if any):	HANDS

Section 3 - Treatment Information

This patient has been under my care and treatment for this medical problem:	
From:	03-21-2019
To:	05-28-2019
Are you presently treating the patient for this medical condition?	
Treatment Intervals:	Monthly
Was the patient seen previously by another physician/practitioner or medical facility for the current disability/illness/injury?	Unknown
If "Yes," enter the date of first treatment?	
At any time during your attendance for this medical problem, has the patient been incapable of performing his/her regular or customary work?	

Section 4 - Claim Information

Date Disability Began:		03-21-2019	
Was the disability caused by an accident or trauma?		Yes	
If "Yes," indicate the date the accident or trauma occurred:		02-15-2019	
Date you released or anticipate releasing patient to return to his/her regular or customary work:			
Patient's disability is permanent and you never anticipate releasing patient to return to his/her regular or customary work:		Yes	
Enter the ICD Diagnosis Code and version for the primary disabling condition that prevents the patient from performing his/her regular or customary work below:			
ICD Diagnosis Code:	M79.641	Diagnosis Code Version:	ICD-10
ICD Diagnosis Code(s) for Secondary Disabling Condition(s):			
ICD Diagnosis Code:	M79.642	Diagnosis Code Version:	ICD-10
ICD Diagnosis Code:		Diagnosis Code Version:	
ICD Diagnosis Code:		Diagnosis Code Version:	
Diagnosis - If no diagnosis has been determined, enter a detailed statement of symptoms:			
Findings - State nature, severity, and extent of the incapacitating disease or injury, including any other disabling conditions:			
Type of treatment/medication rendered to patient:			
If patient was hospitalized, date of entry:			
Date of discharge:			
Patient is still hospitalized?		No	
Is the patient deceased?		No	

EDD Employment Development Department
State of California

Date of death:	
City:	
County:	
State:	
Type of surgery/procedure:	
Date of surgery/procedure:	

Enter the ICD Procedure Code and version for surgery/procedure(s) planned or performed below:			
ICD Procedure Code:		Procedure Code Version:	
ICD Procedure Code:		Procedure Code Version:	
ICD Procedure Code:		Procedure Code Version:	
ICD Procedure Code:		Procedure Code Version:	

Enter the CPT code for surgery/procedure(s) planned or performed below:	
CPT Code:	
CPT Code:	
CPT Code:	
CPT Code:	
Was the patient unable to work immediately prior to the surgery or procedure?	
If "Yes," please provide the first date the patient was unable to work prior to the surgery or procedure?	
Was this disabling condition caused and/or aggravated by the patient's regular or customary work?	Yes
Are you completing this form for the sole purpose of referral/recommendation to an alcoholic recovery home or drug-free residential facility (as indicated by the patient on the DE 2501 Claim for Disability Insurance (DI) Benefits Claimant's Statement)?	No
Date your patient became a resident of a drug or alcohol facility (if known):	
Would disclosure of the information on this form be medically or psychologically detrimental to your patient?	
Is this a pregnancy related claim?	No

Section 5 - Pregnancy Information

Estimated Delivery Date:	
Pregnancy End Date (if applicable):	

If this patient has not delivered and you do not anticipate releasing the patient to return to regular and customary work prior to the estimated delivery date, provide estimates for the number of days you anticipate the patient will be disabled after delivery for the both of the following delivery types:	
Vaginal delivery:	
Cesarean delivery:	

If this patient has delivered, indicate type of delivery and any complications as applicable.	
Type of Delivery:	

If pregnancy is/was abnormal, state the complication(s) causing maternal disability:	

Section 6 - Prognosis Information

What complications make your patient disabled longer than normally expected?	

Section 7 - Physician/Practitioner's Certification

Title of Person:	An authorized physician or practitioner pursuant to California Unemployment Insurance Code Section 2708.
I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the listed disabling condition(s). I have performed a physical examination and/or treated the patient within my scope of practice as an authorized physician or practitioner pursuant to California Unemployment Insurance Code Section 2708.	

Physician/Practitioner Signed:	Yes
Date Signed:	06-14-2019
If government facility, provide facility name:	
If government facility, provide facility address:	

Under Section 2116 and 2122 of the California Unemployment Insurance Code, it is a violation for any individual who, with the intent to defraud, falsely certifies the medical condition of any person in order to obtain disability insurance benefits, whether for the maker or for any other person and is punishable by imprisonment and/or fine not exceeding twenty thousand dollars. Section 1143 requires additional administrative penalties.

Submitted By:	PATRICK O LANG	Entered Date:	06-25-2019 12:00 AM
Entered By:	220-50002	Submitted On:	06-25-2019 12:00 AM